

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2011
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Survey type: This visit was for 1 (one) State licensure hospital complaint.</p> <p>Complaint: #IN00093184 Substantiated; no deficiencies cited related to the allegations.</p> <p>Facility: #003776</p> <p>Date: 11-4-2011</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>Indiana University Health West Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.6.2, Emergency services, and 410 IAC 15-1.5-5, Medical staff, Indiana Hospital Licensure Rules.</p> <p>QA: claughlin 01/10/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

14111

If continuation sheet 1 of 1